

CERTIFICATE OF DEATH

15309

15313

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>	
c. LENGTH OF STAY IN 1b <b>25 years</b>		d. STREET ADDRESS <b>09-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>ARNETT</b> Last <b>ARNETT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 17, 1886</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Arnett</b>		14. MOTHER'S MAIDEN NAME <b>Anna Dean</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-30-8251</b>	
17. INFORMANT <b>Mrs. John A. Arnett, Hurlock, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Distention (convulsion)</b> DUE TO <b>Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic Cardiovascular Disease</b> DUE TO <b>Controlled auricular fibrillation</b> (c) <b>Controlled auricular fibrillation</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Cataracts osteoarthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/4/67</b> to <b>11/24/67</b> , 19__, that (I) (we) last saw the deceased alive on <b>11/23/67</b> , 19__, and that death occurred at <b>12 Noon</b> , from causes and on the date stated above.		22a. SIGNATURE <b>Arnold B. Plummer</b>	
22c. PHYSICIAN'S NAME (Type) <b>Arnold B. Plummer M.D.</b>		22b. DATE SIGNED <b>11/27/67</b>	
22d. ADDRESS <b>Preston Maryland</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 27, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Hurlock, Maryland</b>
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. J. Frampton</b>		25c. REGISTRAR'S SIGNATURE <b>J. J. Frampton</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>1 day 10 hr.</u>		d. STREET ADDRESS <u>23-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LEAR</u> Middle <u>ANNIE</u> Last <u>BOSS</u>		4. DATE OF DEATH Month <u>11</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> (Common law) NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-13-08</u> 9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND U.S.A.</u>
13. FATHER'S NAME <u>Not-listed</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>MARY BOSS</u>	
16. SOCIAL SECURITY NO. <u>Not-listed</u>		17. INFORMANT Address <u>Eastern Shore State Hosp. Med. Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> DUE TO (b) <u>Cirrhosis of liver</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <del>the</del> (this hospital) attended the deceased from <u>10-30</u> , 19 <u>67</u> , to <u>11-1</u> , 19 <u>67</u> , that <u>W</u> (we) lost saw the deceased alive on <u>11-1</u> 19 <u>67</u> , and that death occurred at <u>6:45</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Rieckert</u> M.D.		22b. DATE SIGNED <u>11-1-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Rieckert</u>		22d. ADDRESS <u>E - New Market, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dukes Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Bishop Worcester Md.</u>
24. FUNERAL DIRECTOR <u>Richard T. Watson</u>		25a. REC'D BY REGISTRAR <u>Selbyville, Dela.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 6 1967</u>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15315

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE, MD.</u>		c. LENGTH OF STAY IN 1b <u>24R 10 MC</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Box 205 R.D. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Lee</u> Last <u>BOWDLE</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-87</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>JEWELL BOWDLE</u>	
14. MOTHER'S MAIDEN NAME <u>Emma XXXXXX BAKER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>222-14-5944</u>		17. INFORMANT Address <u>E.S.S. Hosp. Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341</u> <u>Asphyctic pneumonia</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary heart failure</u> DUE TO _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>1/21</u> , 19 <u>67</u> , to <u>11/16</u> , 19 <u>67</u> , that (H) (we) last saw the deceased alive on <u>1-16</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert W. Rieckert</u>		22b. DATE SIGNED <u>11-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Rieckert</u>		22d. ADDRESS <u>E-New Market, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov. 19, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Near Hurlock, Maryland</u>
24. FUNERAL DIRECTOR <u>Tramptown Funeral Home, Federalsburg</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THE STATE OF TEXAS

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15316

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>40</b> Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>317 Maryland Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Willie May Thomas Brocato</b>		4. DATE OF DEATH <b>November 3, 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1889</b>
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cambridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James R. Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Lena Barrack</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-32-1479</b>	
17. INFORMANT <b>Joseph S. Brocato, Jr., Cambridge, Md.</b>		18. ADDRESS <b>4405 Radiance Dr</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace, Jr., M.D.</b>		22. DATE SIGNED <b>11/3/67</b>	
EXAMINER'S NAME (Type) <b>John Mace, Jr., M.D.</b>		22b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 5, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Md.</b>	
24. FUNERAL DIRECTOR <b>James R. Thomas</b>		25. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
ADDRESS <b>Cambridge, Md.</b>			

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STATE OF MARYLAND

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15313

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1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock, Md. RFD.</b>	
c. LENGTH OF STAY IN 1b <b>75 yrs.</b>		d. STREET ADDRESS <b>none</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>F. Elwood Cohee</b>		4. DATE OF DEATH Month <b>II</b> Day <b>17</b> Year <b>67</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1888</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>9</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Caroline Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank H. Cohee</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Coubourne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> <b>W. W. I</b>		16. SOCIAL SECURITY NO. <b>215-36-1320</b>	
17. INFORMANT <b>Dorothy M. Cohee</b>		Address <b>Hurlock, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic heart disease</b> (c) DUE TO cause last, stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 23, 1967</b> to <b>November 17, 1967</b> that (I) (we) last saw the deceased alive on <b>November 17, 1967</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Carlos F. Barros</b>		22b. DATE SIGNED <b>November 20 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARROSO MD</b>		22d. ADDRESS <b>S. Main St. Hurlock Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>II/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Hurlock, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey Williams</b>		25a. REC'D BY REGISTRAR <b>NOV 24 1967</b>	
ADDRESS <b>Federalburg, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11015

## CERTIFICATE OF DEATH

1-5-18

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>RURAL - CHRIST ROCK</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RFD #1 CAMBRIDGE, MD.</b>		d. STREET ADDRESS <b>RFD 1 CAMBRIDGE, MD.</b>	
3 NAME OF DECEASED (Type or print) <b>LILLIAN THOMPSON CONAWAY</b>		4 DATE OF DEATH Month <b>NOVEMBER</b> Day <b>19</b> Year <b>1967</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>NEGROID</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DECEMBER 27, 1923</b> 43 yrs
9 AGE (In years lost birthday)		10 UNDER 1 YEAR Months Days Hours Min	11 UNDER 24 HRS
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER CO., MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>FRANCIS THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>AGNES PINDER</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16 SOCIAL SECURITY NO <b>220-10-6408</b>	
17 INFORMANT <b>AGNES P. THOMPSON</b>		Address <b>RFD #2 CAMBRIDGE, MD.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO (b) <b>Hypertension, malignant in type</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. pm <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 1967, to <b>Nov-19</b> , 1967 that (I) (we) last saw the deceased alive on <b>Nov-18</b> , 1967 and that death occurred at <b>11 P</b> M, from causes on and on the date stated above			
22a SIGNATURE <b>J. U. THOMPSON, M.D.</b>		22b DATE SIGNED <b>11/22/67</b>	
22c PHYSICIAN'S NAME (Type)		22d ADDRESS <b>602 LOCUST STREET CAMBRIDGE, MD.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/24/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>FORK NECK</b>	23d LOCATION (City or Town) (County) (State) <b>FORK NECK DOR. MD.</b>
24 FUNERAL DIRECTOR <b>Frederick C. Davis</b>		25a REC'D BY REGISTRAR <b>NOV 27 1967</b>	
ADDRESS <b>CAMBRIDGE, MD.</b>		25b REGISTRAR'S SIGNATURE <b>William Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15719

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before adm ssion) a. STATE <u>Md</u> b. COUNTY <u>Dorchester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sales town</u>		c LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>REF 3</u>		d STREET ADDRESS <u>REF 3</u>	
3 NAME OF DECEASED (Type or print) <u>Mary Elizabeth Corey</u>		4 DATE OF DEATH <u>11 / 16</u> 19 <u>67</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Oct 25 1875</u>
9 AGE (In years last birthday) <u>92</u> yrs		10 IF UNDER 1 YEAR Months Days	11 IF UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11 BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>
12 CITIZEN OF WHAT COUNTRY? <u>US</u>		13 FATHER'S NAME <u>Lambert Littleton</u>	
14 MOTHER'S MAIDEN NAME <u>Sarah Moore</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO <u>141-22-1156</u>		17 INFORMANT <u>Mr Thomas Russell</u> Address <u>Gales town - Md</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>General Arterio Sclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>General Arterio Sclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>154 hrs</u>
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/16</u> , 19 <u>60</u> , to <u>11/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/16</u> , 19 <u>67</u> , and that death occurred at <u>2 A</u> M, from causes on and on the date stated above			
22a. SIGNATURE <u>H S Kuhlman</u>		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>H S Kuhlman</u>		22d ADDRESS <u>Shapton Md</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF <u>11/14/67</u>	23c NAME OF CEMETERY OR CREMATORY <u>Union Cem</u>	23d LOCATION (City or Town) (County) (State) <u>Shapton Dorchester, Del</u>
24 FUNERAL DIRECTOR <u>William J. Mandy</u>		25a REC'D BY REGISTRAR <u>DAV NOV 22 1967</u> 25b REGISTRAR'S SIGNATURE <u>Genorio Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Bf

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN ID <u>6 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Church Creek</u>	
3. NAME OF DECEASED (Type or print) First <u>Harold</u> Middle <u>Murst</u> Last <u>Delaha</u>		4. DATE OF DEATH <u>Nov. 10, 1967</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 23, 1898</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigerated shipping clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Daniel F. Delaha</u>		14. MOTHER'S MAIDEN NAME <u>Laura F. Murst</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>210-20-1421</u>	
17. INFORMANT <u>rs. Lillie V. Delaha</u>		Address <u>Church Creek, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> DUE TO (b) <u>Atherosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Congestive Heart Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> , 19 <u>67</u> , to <u>11-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-10</u> , 19 <u>67</u> , and that death occurred at <u>PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 12, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Old Trinity Churchyard</u>		23d. LOCATION (City, town or county) (State) <u>Church Creek, Md.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
25c. ADDRESS <u>Cambridge, Md.</u>		25d. DATE <u>NOV 16 1967</u>	



VR A15ME (5)  
6M 1/66

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b>		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Cambridge</b>		c. LENGTH OF STAY N 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
d. NAME OF HOSPITAL, DR INSTITUTE (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		U.S. Rt. 50	
3 NAME OF DECEASED (Type or print) <b>CARRIE</b>		First <b>HESTER</b> Middle <b>ELLIOTT</b> Last		4 DATE OF DEATH <b>Nov.</b> Month <b>19</b> Day <b>19</b> Year <b>67</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH <b>March 18 1888</b>		9. AGE (In years last birthday) <b>79</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN - None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Delaware</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Mary Donoway</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Med. Records</b> Address <b>Eastern Shore State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>904.7</b> DUE TO (b) <b>Terminal Pneumonia</b> DUE TO (c) <b>Fracture Neck R. Femur</b> DUE TO (d) <b>6 Mo</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		22. ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <b>X</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fall in hospital</b>		20c. TIME OF INJURY Month, Day, Year <b>5/24 19 67</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street off ce bldg, etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Cambridge, Wic. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>11/20/67</b>		23. ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.	
24. EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>		25. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		26. ADDRESS (Street, city, town, or county)	
27a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		27b. DATE THEREOF <b>Nov. 22, 1967</b>		27c. NAME OF CEMETERY OR CREMATORY <b>Pittsville Cemetery</b>	
27d. LOCATION (City or Town) (County) (State) <b>Pittsville, Maryland</b>		28a. REC'D BY REGISTRAR <b>NOV 21 1967</b>		28b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>	
29. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		30. ADDRESS		31. ADDRESS	



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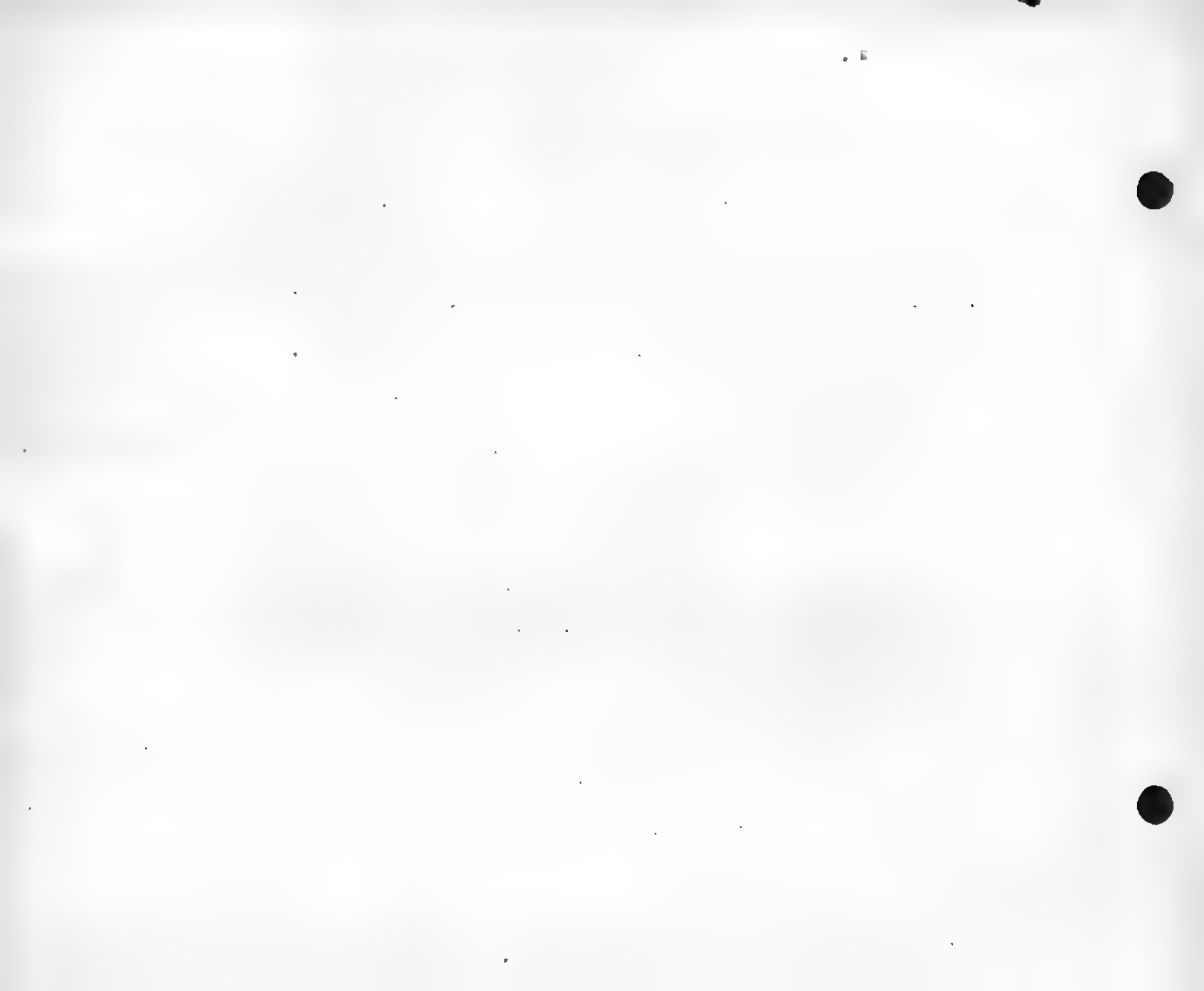
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1328

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>lifetime</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge-Md. Hospital</u>				d. STREET ADDRESS <u>709 Locust St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Cornelia</u> Last <u>Elliott</u>				4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 4, 1909</u>			
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Yacht Club</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elliott, Md.</u>			
13. FATHER'S NAME <u>Pilbourne Elliott</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Harding</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Pilbourne Elliott</u> Address <u>709 Locust St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO <u>Coronary occlusion, Myocard</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Arteriosclerosis, gen</u> (c) <u>Diabetes mellitus, 4 obesity simple</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u> <u>1 hr.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>				20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>					
20f. (City or town) (County) (State) <u>  </u>				21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>66</u> , to <u>11/12</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>James W. Thompson</u> M.D.				22b. DATE SIGNED <u>  </u>					
22c. PHYSICIAN'S NAME (Type) <u>  </u>				22d. ADDRESS <u>Cambridge Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/13/14/67</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Cambridge Md.</u>					
24. FUNERAL DIRECTOR <u>Reverend R. Thomas Jr.</u> ADDRESS <u>Cambridge Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 16 1967</u>					
25b. REGISTRAR'S SIGNATURE <u>James W. Thompson</u>									





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15219

15023

FOR STATE HEALTH

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dor</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HURLOCK RFD all ex</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D.</b>		d. STREET ADDRESS <b>R.F.D.</b>	
3. NAME OF DECEASED (Type or print) <b>George Penfold Emerson</b>		4. DATE OF DEATH Month <b>11</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. CO. OR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/24/1889</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days	
10a. U.S. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Emerson</b>		14. MOTHER'S MAIDEN NAME <b>Donna Emerson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>123-45-6789</b>	
17. INFORMANT <b>Th. Hagel Emerson Hurlock Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.)	20f. City or town County State
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.		22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>		Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR REPOSITORY	23d. LOCATION, city or town
24. FUNERAL DIRECTOR	25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15320

1324

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Dor.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN <u>Days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>		d. STREET ADDRESS <u>Vienna</u>		
3. NAME OF DECEASED (Type or print) <u>Shelton Elwood Gray</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1967</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/1888</u>	
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant-Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Abelieu Gray</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ewell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes W.W.I</u>		16. SOCIAL SECURITY NO		
17. INFORMANT <u>Moody S. Gray, Vienna, Md</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Adenocarcinoma of</u> DUE TO <u>stomach with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>metastases</u> DUE TO (c) <u>metastases</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1 1967</u> , 19 <u>55</u> , to <u>Nov 2 1967</u> , that (I) (we) last saw the deceased alive on <u>Nov 1 1967</u> and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above				
22a. SIGNATURE <u>Lewis Burdette</u>		22b. DATE SIGNED <u>Nov 2, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Lewis Burdette</u>		22d. ADDRESS <u>4 Annapolis St, Cambridge, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Cambridge Md</u>	
24. FUNERAL DIRECTOR <u>Ruth S. Mulroughy, East New Market, Md</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>NOV 7 1967</u>		
25b. REGISTRAR'S SIGNATURE				



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101

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15321

15325

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>4 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>311 Washington Street</b>		e. STREET ADDRESS <b>311 Washington Street</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>OLLIE ARNETT GRIFFITH</b>		4 DATE OF DEATH Month Day Year <b>November 25 1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>July 4, 1877</b>
9 AGE (In years, months, and days) <b>90</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Arnett</b>		14 MOTHER'S MAIDEN NAME <b>Anna Dean</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO <b>216-09-4876</b>	
17 INFORMANT <b>Mrs. Lloyd Perry, Preston, Maryland</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident (Thrombosis)</b> DUE TO (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerotic heart disease.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>25 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <b>Arteriosclerotic heart disease.</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>June 18, 1967</b> to <b>November 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>November 25, 1967</b> , and that death occurred at <b>8:30 PM</b> from causes and on the date stated above			
22a. SIGNATURE <b>Carlos F. Barros</b>		22b. DATE SIGNED <b>11-27-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARROSO</b>		22d. ADDRESS <b>S. Main St. Hurlock, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 28, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hurlock, Maryland</b>	
24 FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Judge</b>			





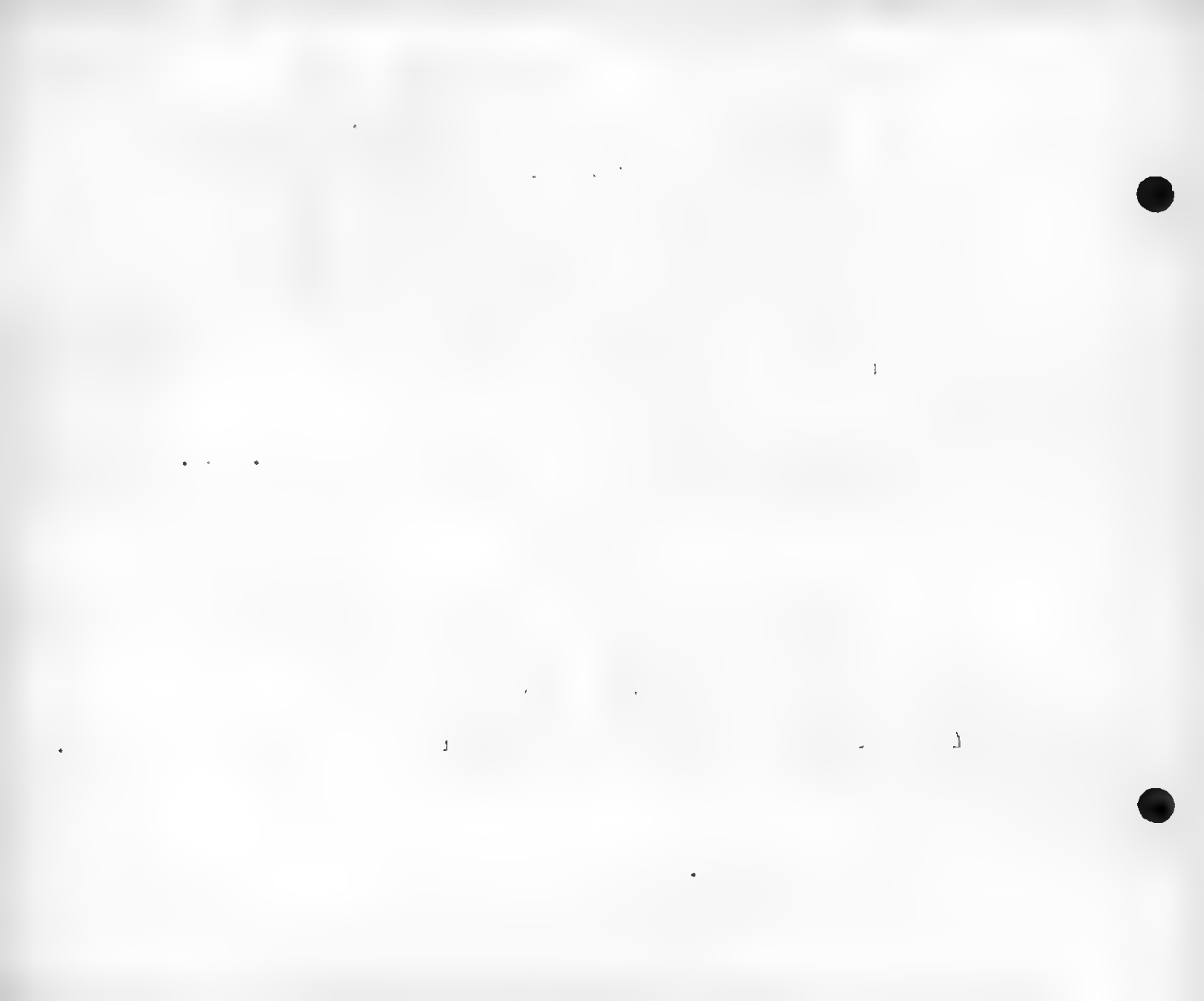
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15326

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 4) to the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

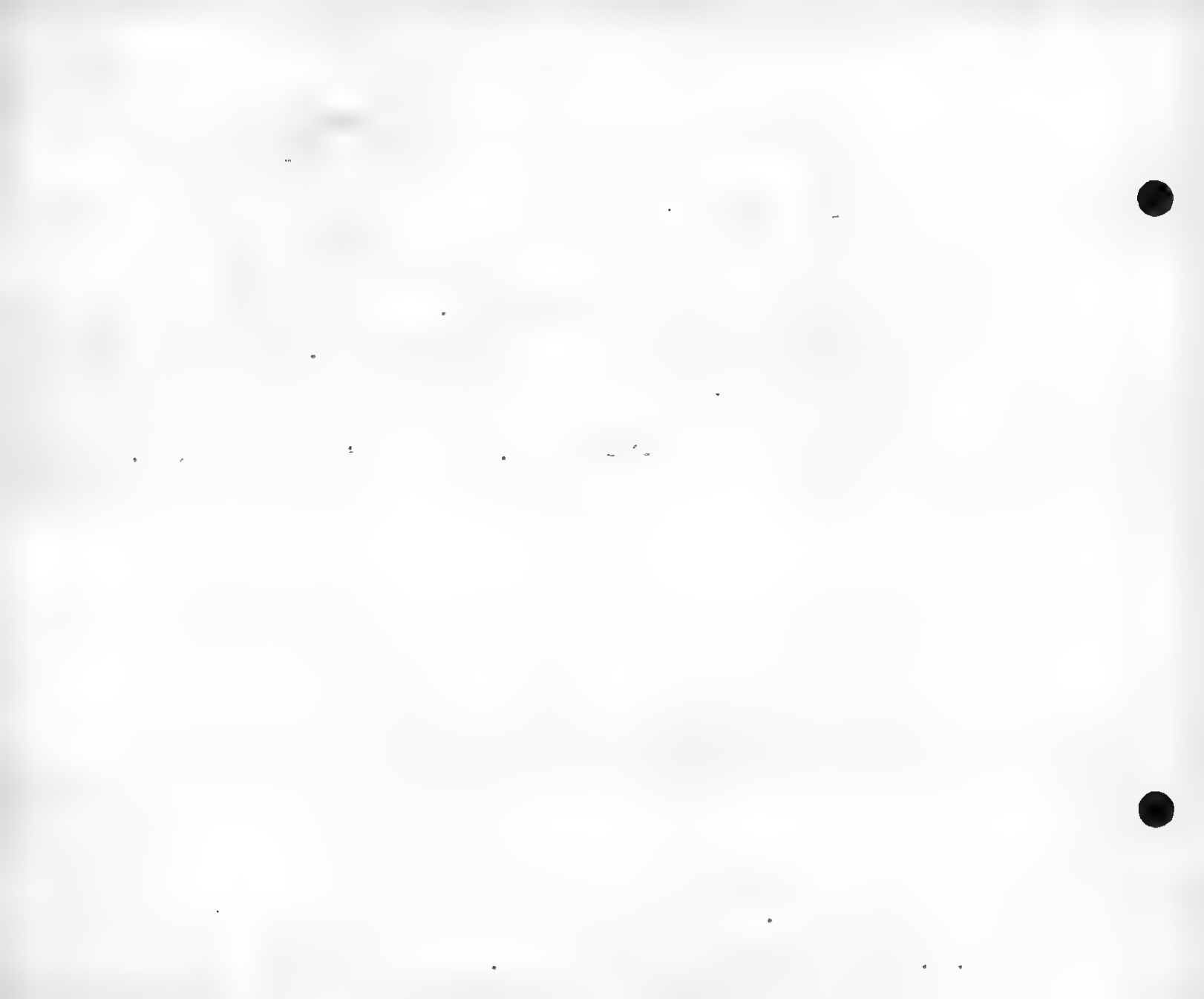
1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>KENT</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN I.B. <b>1 YR. 3 MO.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>SARAH</b> Middle <b>JOYNER</b> Last <b>HICKEY</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>10/2/84</b>
9 AGE (In years last birthday) <b>83</b> yrs		10 UNDER 24 HRS Months Days Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11 BIRTHPLACE (State or foreign country) <b>MD.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>SAMUEL JOYNER</b>		14 MOTHER'S MAIDEN NAME <b>SARAH DEFORD</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>		16 SOCIAL SECURITY NO <b>705-12-4415</b>	
17 INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>E.S.S.H.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>9047</b> IMMEDIATE CAUSE (a) <b>TERMINAL PNEUMONIA</b> DUE TO (b) <b>FRACTURE NECK OF RIGHT FEMUR</b> DUE TO (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>1 MO.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>FELL IN HOSPITAL</b>	
20c TIME OF INJURY Month, Day, Year Hour am pm <b>10/20/67</b> 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOSPITAL</b>	20f (City or town) (County) (State) <b>CAMBRIDGE DOR. MD.</b>
21. I certify that took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>11/20/67</b>	
EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, RE-MOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>Nov. 23</b>	23c NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel</b>	23d LOCATION (City or town) (County) (State) <b>Rock Hall Maryland</b>
24 FUNERAL DIRECTOR <b>Edgar Lane Church Hill Md.</b>		25a RECD BY REGISTRAR <b>DATE NOV 27 1967</b>	25b REGISTRAR'S SIGNATURE <b>Arthur Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c LENGTH OF STAY IN lb <b>51 days</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge - Rural</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS <b>Town Point</b>			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>LEE</b> Last <b>HIGGINS</b>					4 DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>19 67</b>				
5. SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 8, 1889</b>		9 AGE (In years last birthday) <b>78</b> YES	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer and Waterman</b>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>			12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13 FATHER'S NAME <b>James Merritt Higgins</b>					14 MOTHER'S MAIDEN NAME <b>Della Larrimore</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16 SOCIAL SECURITY NO. <b>219-14-4546</b>		17. INFORMANT Address <b>H. Jerome Higgins, Cambridge, Md., RFD</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>54 days</b> <b>5 yrs.</b>									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/2/67</b> , 19 <b>67</b> , to <b>11/29/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/29/67</b> , 19 <b>67</b> , and that death occurred at <b>9:20 AM</b> , from causes and on the date stated above.									
22a SIGNATURE <b>Lawrence Maryanov</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED <b>12/1/67</b>		
22c PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov, MD</b>					22d ADDRESS <b>Cambridge, Md</b>				
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Dec. 2, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>East New Market, Maryland</b>		
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Md.</b>					25a REC'D BY REGISTRAR DATE <b>DEC 5 1967</b>		25b REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		



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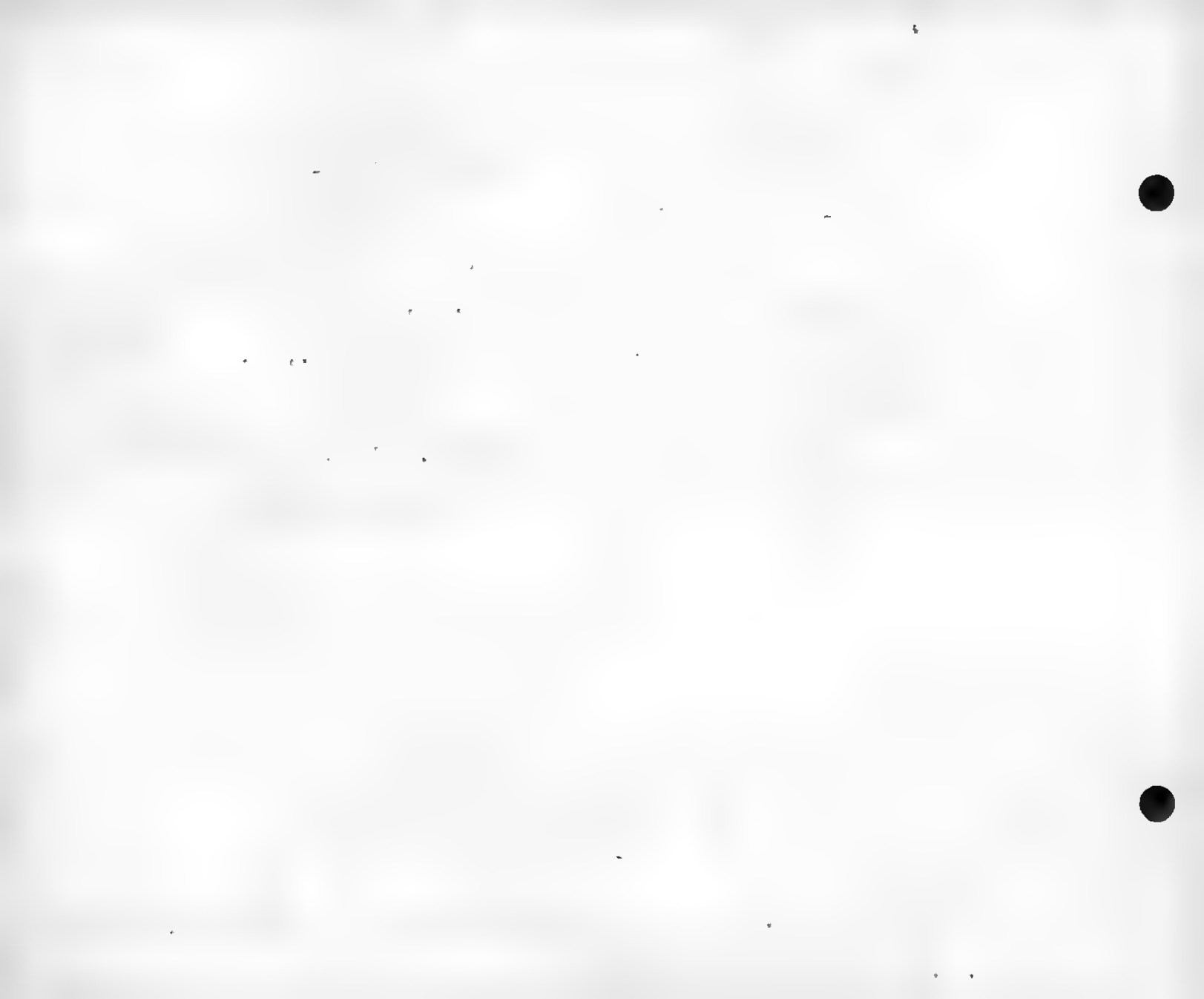
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10028

1 PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cambridge</b>			c LENGTH OF STAY N 1b <b>DOA</b>			c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Hurlock - Rural</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				d STREET ADDRESS <b>Petersburg</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>CLIFTON</b> Last <b>JOLLEY</b>				4 DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>19 67</b>			
5 SEX <b>Male</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Nov. 26, 1914</b>	9 AGE (In years lost birthday) <b>52</b> yrs	IF UNDER 1 YEAR Months <b>5</b> Days <b>21</b> Hours <b>67</b>	IF UNDER 24 HRS Hours <b>67</b> Min <b>19</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Canning Factory</b>		11 BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>James Jolley</b>				14 MOTHER'S MAIDEN NAME <b>Laura Rideout</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>WWII</b>		16 SOCIAL SECURITY NO <b>Unknown</b>		17 INFORMANT Address <b>Hattie M. Jolley, Sherwood, Maryland</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic alcoholism, fatty liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>7</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) _____ (County) _____ (State) _____	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John M. Jolley</i> EXAMINER'S NAME (Type) _____				22. DATE SIGNED <b>11/28/67</b> <b>Cambridge, Md.</b>			
23a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Nov. 25, 1967</b>		23c NAME OF CEMETERY OR CREMATORY <b>Petersburg Cemetery</b>		23d LOCATION (City, Town, County, State) <b>Near Hurlock, Maryland</b>	
24 FUNERAL DIRECTOR <i>J. J. Frampton</i> <b>J. J. Frampton and Son, Federalburg, Maryland</b>				25a RECD BY REGISTRAR <b>NOV 30 1967</b>		25b REGISTRAR'S SIGNATURE <i>James J. Jolley</i>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director, Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you or your health officer. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH  
a. COUNTY **Dorchester** MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Rural-Cambridge** c. LENGTH OF STAY IN b **1 day**  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **DOA Cambridge Maryland Hospital**

2. USUAL RESIDENCE (Where deceased lived. If institutional, Res. date birth) a. STATE **Maryland** b. COUNTY **Baltimore**  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Ellicott City 21043** d. STREET ADDRESS **186 Meadowvale Rd.**  
e. IS RESIDENCE ON A F.R.M? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) **Alfred William Kabernagel** First Middle Last  
4. DATE OF DEATH **Nov. 28 1967** Month Day Year  
5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ B. DATE OF BIRTH **April 16 1896** 9. AGE (In years last birthday) **71** yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Maryland Port Authority, Retired** 10b. KIND OF BUSINESS OR INDUSTRY **Maryland** 11. BIRTHPLACE (State or foreign country) **U.S.A.** 12. CITIZEN OF WHAT COUNTRY?  
13. FATHER'S NAME **William Kabernagel** 14. MOTHER'S MAIDEN NAME **Augusta Depkin**  
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO **WW 1 & 2 215 38 9199** 17. INFORMANT **Mrs. Genevieve McCann Kabernagel** Address **186 Meadowvale Rd.**  
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **Coronary occlusion** (b) (c)  
4201 DUE TO  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒  
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)  
Hour a.m. p.m. 19 While at work ☐ Not While at work ☐  
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐  
CHIEF MEDICAL EXAMINER ☐  
ACTUAL SIGNATURE **John Mace Jr.** M.D. ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED **11/29/67**  
EXAMINER'S NAME (Type) **John Mace Jr.** DEPUTY MEDICAL EXAMINER ☒  
Address (Street, city, town, or county) **Cambridge, Md.** 22d. LOCATION (City, town, or country) (State)  
22a. BURIAL, CREMATION REMOVAL (Specify) **Burial** 22b. DATE THEREOF **12/1/67** 22c. NAME OF CEMETERY OR CREMATORY **Baltimore National** ADDRESS **Baltimore Md.**  
23. FUNERAL DIRECTOR **Henry Sander & Sons, Baltimore, Maryland** 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE **Charles Judge**  
**DEC 1 1967**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion) a. STATE <u>MD.</u> b. COUNTY <u>WIC</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE MD</u>		c. LENGTH OF STAY IN TB <u>20 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>HEBRON MD RURAL</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u>		4. DATE OF DEATH Month <u>11</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-07</u>
9. AGE (n years last birthday) <u>60</u> yrs		10. F UNDER 1 YEAR Months Days F UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during mos of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <u>WILMINGTON, DEL.</u>		12. C Y ZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE Wm. KAIN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA DENNISON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>221-05-1406</u>	
17. INFORMANT <u>EASTERN SHORE STATE Hosp RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Peri Aortic</u> DUE TO <u>small bowel obstruction</u> (b) <u>Carcinoma of recto-sigmoid</u> DUE TO <u></u> (c) <u></u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (H) (this hospital) attended the deceased from <u>11-16</u> 19 <u>67</u> , to <u>11-17</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11-16</u> 19 <u>67</u> , and that death occurred at <u>11:00</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>John W. Rieckert</u> M.D.		22b. DATE SIGNED <u>11-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>John W. Rieckert</u>		22d. ADDRESS <u>E - New Market Rd</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Cem</u>	23d. LOCATION (City or town) (County) (State) <u>Salmon Del</u>
24. FUNERAL DIRECTOR <u>M. E. Manuel</u>		25a. REC'D BY REGISTRAR <u>W. E. Jones</u>	
25b. REGISTRAR'S SIGNATURE <u>W. E. Jones</u>		DATE <u>NOV 20 1967</u>	



## CERTIFICATE OF DEATH

15231

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN 1b <b>3½ YRS.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. STREET ADDRESS <b>DENTON</b>	
3. NAME OF DECEASED (Type or print) First <b>GOTTLOB</b> Middle <b>KLEIN</b> Last <b>KLEIN</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/79</b>
9. AGE (In years lost birthday) <b>88 yrs</b>		10. IF UNDER 1 YEAR Months <b>88</b> Days <b>88</b> Hours <b>88</b> Min. <b>88</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GERMANY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHRISTIAN KLEIN</b>		14. MOTHER'S MAIDEN NAME <b>FREDERIKA TRUMETER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO <b>213-50-4005</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <b>440X</b> IMMEDIATE CAUSE (a) <b>Pneumonia, lobar</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Senile cachexia</b> (c) <b>1 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Uremia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 'o'm. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/23</b> , 1964, to <b>11/3</b> , 1967, that (I) (we) last saw the deceased alive on <b>11/3</b> , 1967, and that death occurred at <b>12:40M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Carlos F. Barrios</b>		22b. DATE SIGNED <b>11/3/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>CARLOS F. BARRIOS</b>		22d. ADDRESS <b>E.S.S. HOSPITAL, CAMBRIDGE, MD.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>Nov 2, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>	23d. LOCATION (City or town) (County) (State) <b>Denton Ind</b>
24. FUNERAL DIRECTOR <b>Charles Moore Denton</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 8 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 (page 5 may be retained for your files).  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 5)  
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15732

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY IN Id <b>1 day</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Cambridge Md. Hospital</b>		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) <b>Mary Clara Mantik</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>20</b> Year <b>19 67</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Aug 20, 1880</b>
9 AGE (in years last birthday) yrs <b>87</b>		FUNDER 1 YEAR Months <b>87</b> Days <b>87</b>	IF UNDER 24 HRS Hours <b>87</b> Min <b>87</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11 BIRTHPLACE (State or foreign country) <b>Poland</b>
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13 FATHER'S NAME <b>John Safranski</b>	
14 MOTHER'S MAIDEN NAME <b>Anna Ciepenski</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16 SOCIAL SECURITY NO		17 INFORMANT Address <b>Mr. Robert Chambers, York, Pa.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>4201</b> (c) <b>4201</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		22. DATE SIGNED <b>11/24/67</b>	
EXAMINER'S NAME Type <b>John Mace Jr. M.D.</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b DATE THEREOF <b>11/24/67</b>	23c NAME OF CHURCH OR CREMATORY <b>Our Lady of Good Council</b>	23d LOCATION (City or Town) (County) (State) <b>Dorchester, Md.</b>
24 FUNERAL DIRECTOR <b>W. S. Hulloughby</b>		25a REF'D BY REGISTRAR <b>NOV 27 1967</b>	25b REGISTRAR'S SIGNATURE <b>William A. Judge</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>about 10 yrs</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>Cambridge, Maryland Hospital</b>					<b>d. STREET ADDRESS</b> <b>321 Henry Street</b>			<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>LUIA</b> Middle <b>SAYLOR</b> Last <b>METCALF</b>					<b>4. DATE OF DEATH</b> Month <b>Nov.</b> Day <b>24</b> Year <b>1967</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>March 12, 1913</b>		<b>9. AGE</b> (In years last birthday) <b>54</b> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS: Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Stoney Fork, Kentucky</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Frank Saylor</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Olive Blizzard</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>unk</b>		<b>17. INFORMANT</b> <b>Mrs. Omie Cantrell, Cambridge, Maryland</b>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLISM</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____									<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>MINUTES</b>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>									<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)						
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>		
<b>21. I certify that (1) (this hospital) attended the deceased from <u>11-23</u>, 19<u>67</u>, to <u>11-24</u>, 19<u>67</u>, that (2) (we) last saw the deceased alive on <u>11-24</u>, 19<u>67</u>, and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <i>James F. McCarter</i>					<b>22b. DATE SIGNED</b> <b>11-27-67</b>			<b>22c. PHYSICIAN'S NAME</b> (Type) <b>JAMES F. MCCARTER</b>	
<b>22d. ADDRESS</b> <b>Box 386</b> <b>CAMBRIDGE, M.D. 21613</b>					<b>22e. MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>Nov 28, 1967</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Greenlawn Cemetery</b>			<b>23d. LOCATION (City, town or county) (State)</b> <b>Cambridge, Maryland</b>	
<b>24. FUNERAL DIRECTOR</b> <b>LeCompte Funeral Service, Cambridge, Maryland</b>					<b>25a. REC'D BY REGISTRAR</b> <b>NOV 29 1967</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>35 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>720 Peach Blossom Ave.</u>						d. STREET ADDRESS <u>72 Peach Blossom Ave.</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louis William Meyer</u>						4. DATE OF DEATH Month Day Year <u>Nov. 23, 1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12, 1895</u>		9. AGE (In years last birthday) <u>72 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min <u>19</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cambridge, L.D.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Berlin L. Meyer</u>						14. MOTHER'S MAIDEN NAME <u>Clara Hagel</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO		17. INFORMANT <u>Elizabeth K. Meyer, Cambridge, Md.</u>					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (c)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Cambridge, Md.</u>					
						Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 3, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Md.</u>		23d. LOCATION (City or Town) (County) (State)		22. DATE SIGNED <u>11/29/67</u>			
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas</u> Cambridge, Md.						25a. REC'D BY REGISTRAR DATE <u>DEC. 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

ACTUAL  
SIGNATURE \_\_\_\_\_  
EXAMINER'S  
NAME (Type) \_\_\_\_\_

23o BURIAL, CREMATION,  
REMOVAL (Specify)  
**Burial**

## 24. FUNERAL DIRECTOR

LeCompte Funeral Service, Cambridge, Maryland

ADDRESS

25a REC'D BY REGISTRAR  
NOV 29 1967  
DATE

25b. REGISTRAR'S SIGNATURE

250. REGISTRAR'S SIGNATURE  
*Charles Judge*

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>		2. USUAL RESIDENCE (Where deceased lived, if not full-on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>20 years</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>513 Academy Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROLAND A. MOWBRAY</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>24</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 19, 1898</b>
9. AGE (In years lost birthday) <b>69</b>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Dirt</b>	
13. BIRTHPLACE (State or foreign country) <b>Dorchester County, Md.</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>William Mowbray</b>		16. MOTHER'S MAIDEN NAME <b>Sallie Thomas</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		18. SOCIAL SECURITY NO. <b>unk</b>	
19. INFORMANT <b>Mrs Roland Woolford, RFD 3, Cambridge, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
22. DATE SIGNED <b>11/24/67</b>		23. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 26 1967</b>	
23c. LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>		23d. REC'D BY REGISTRAR <b>NOV 29 1967</b>	
23e. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>	

VR A15MB (5)  
6M 1/64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15332

15335

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Franklin Nichols</u>		4. DATE OF DEATH Month <u>11</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/17/1887</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life. Even if retired) <u>Ret. Carpenter</u>		9b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs <u>80</u>
10. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CRIMINAL RECORD <u>U.S.A.</u>	
11. FATHER'S NAME <u>William Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Marine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Thomas F. Nichols</u>		Address <u>Hurlock</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X</u> DUE TO (b) <u>CEREBRAL HEMORRHAGE</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>under</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/12</u> , 19 <u>67</u> , to <u>11/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>11/13</u> , 19 <u>67</u> , and that death occurred at <u>8:35 PM</u> , from causes and on the date stated above			
22a. SIGNATURE <u>Alfred R. Marynowicz</u>		22b. DATE SIGNED <u>11/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred R. Marynowicz M.D.</u>		22d. ADDRESS <u>610 Race St., Cambridge Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11/16/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eldorado</u>	23d. LOCATION (City or town) (County) (State) <u>Eldorado Dor Md</u>
24. FUNERAL DIRECTOR <u>Ruth S. Hallingby, East New Market</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 17 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





VR A15 (4)  
ZOM 1/65

## 45233

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>32 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>912 Talisman Lane</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>XXX Cambridge Md.</u>	
f. STREET ADDRESS <u>912 Talisman Lane</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eva</u> Middle <u>Laing</u> Last <u>Phelps</u>		4. DATE OF DEATH Month <u>November</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 10, 1909</u>
9. AGE (in years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Willis W. Laing</u>		14. MOTHER'S MAIDEN NAME <u>Clara</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Emerson Elzey Cambridge Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis, acute infarction</u> DUE TO (b) <u>Arterio-sclerotic CVD</u> DUE TO (c) <u>Arterio-sclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerotic</u> 21. I certify that (I) (this hospital) attended the deceased from <u>11/12, 1967</u> , to <u>11/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/12, 1967</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11/12, 1967</u> , to <u>11/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>11/12, 1967</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>James G. Thompson</u>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>James G. Thompson</u>			
22d. ADDRESS <u>Cambridge, Md.</u>			
22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Nov. 14, 1967</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>			
23d. LOCATION (City, town or county) (State) <u>Cambridge Md.</u>			
24. FUNERAL DIRECTOR <u>Kenneth R. Thompson</u>			
24a. ADDRESS <u>Cambridge Md.</u>			
24b. REC'D BY REGISTRAR <u>NOV 16 1967</u>			
24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>					c. LENGTH OF STAY IN 1b <b>one day</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>					d. STREET ADDRESS <b>Golden Hill</b>				
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>RUSSELL</b> Last <b>PHILLIPS</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>26</b> , Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 30, 1910</b>		9. AGE (In years last birthday) <b>57</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dirt</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James E. Phillips</b>					14. MOTHER'S MAIDEN NAME <b>Etta V. Tyler</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT <b>Mrs. Evelyn Hess, Cambridge, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lungs</b> DUE TO (b) <b>Carcinoma of Lungs</b> DUE TO (c) <b>Carcinoma of Lungs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b> <b>8 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> ND <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>April, 1967</b> , to <b>11-26, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-26-67</b> 19 <b>67</b> , and that death occurred at <b>5:30</b> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <b>Wilbur N. Baumann, M.D.</b>					22b. DATE SIGNED <b>11-27-67</b>				
22c. PHYSICIAN'S NAME (Type) <b>Wilbur N. Baumann, M.D.</b>					22d. ADDRESS <b>Aurora Street, Cambridge, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov 29 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Golden Hill, Dor. Co., Md.</b>		
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>					25a. REC'D BY REGISTRAR <b>NOV 29 1967</b>				
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

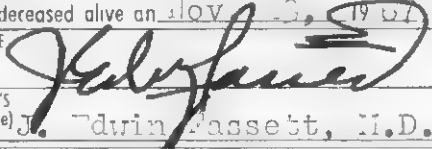

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15335

CERTIFICATE OF DEATH

15338

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>5</b> days	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>			d. STREET ADDRESS <b>Petersburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>JACOB LEHMAN PINCKNEY</b>			4. DATE OF DEATH Month <b>November</b> Day <b>21</b> Year <b>1967</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 8, 1892</b>		9. AGE (In years lost birthday) <b>75</b> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Factory</b>		11. BIRTHPLACE (County & State, or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>245-18-8475</b>		17. INFORMANT Address <b>Essie M. Washington, Hurlock, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> 31X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 17, 1967</b> , to <b>Nov. 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>Nov. 23, 1967</b> and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>J. Edwin Bassett, M.D.</b>		22d. ADDRESS <b>302 High Street, Camb., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rhodesdale Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Near Rhodesdale, Maryland</b>		25a. REC'D BY REGISTRAR <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25b. REGISTRAR'S SIGNATURE 	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

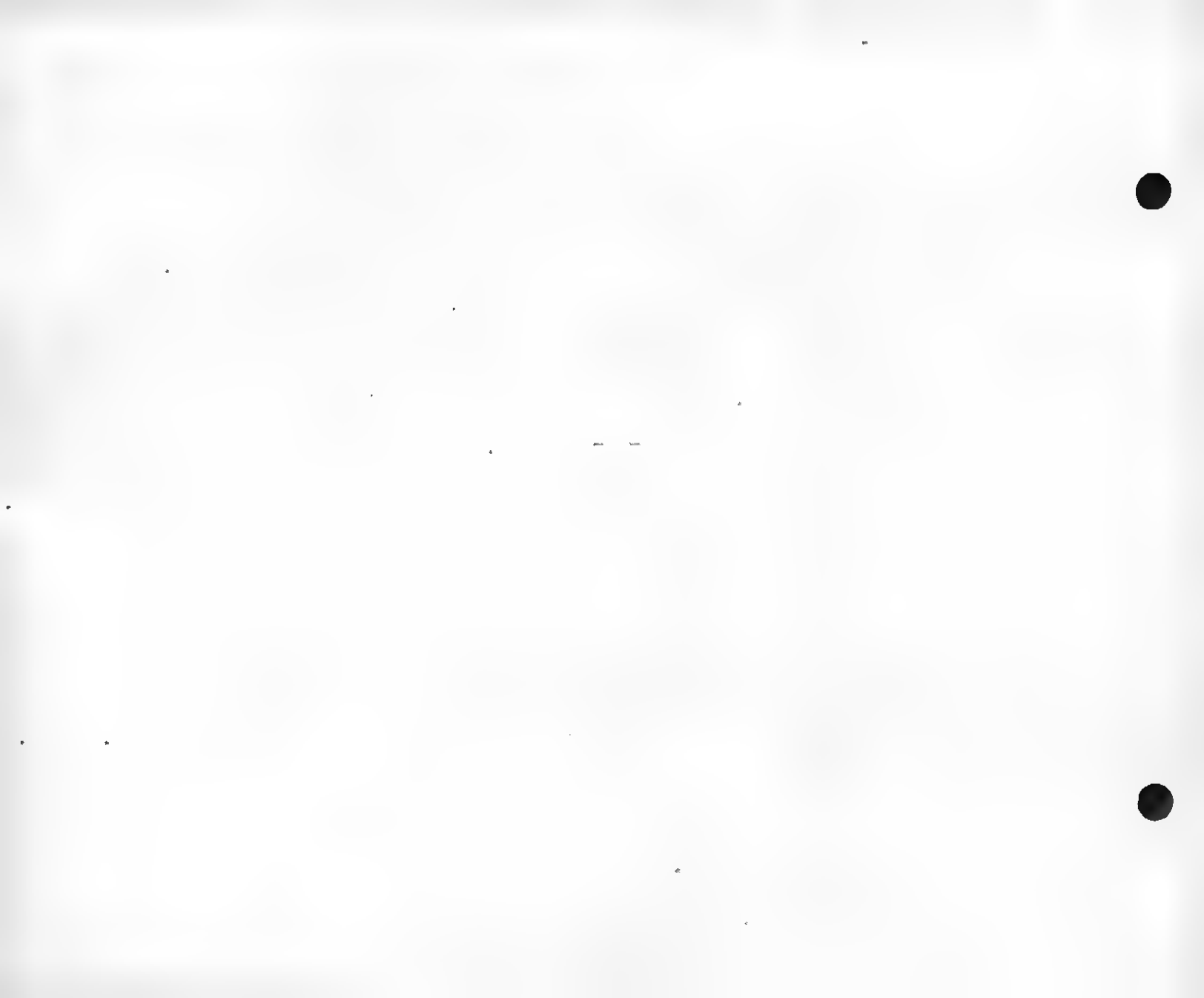
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15236

152369

1 PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wingate</b>		c LENGTH OF STAY IN 1b <b>Life</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DQA Cambridge Maryland Hospital</b>		d STREET ADDRESS <b>None</b>	
3 NAME OF DECEASED (Type or print) First <b>TOMMIE</b> Middle <b>L.</b> Last <b>POWLEY</b>		4 DATE OF DEATH Month <b>Nov. 13</b> Day <b>19</b> Year <b>67</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Feb. 19, 1922</b>
9 AGE (In years last birthday) <b>45</b> yrs		IF UNDER 1 YEAR Months <b>11</b> Days <b>13</b> Hours <b>19</b> Min <b>45</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11 BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Thomas R. Powley</b>		14 MOTHER'S MAIDEN NAME <b>Archie I. Jones</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give year or dates of service) <b>Yes WW 11</b>		16 SOCIAL SECURITY NO. <b>217-16-9224</b>	
17 INFORMANT <b>Mrs. Carrie F. Powley, Wingate, Maryland</b>		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carbon Monoxide poisoning</b> DUE TO <b>9731</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Few min.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8) <b>Hose from exhaust ran into car.</b>	
20c TIME OF INJURY Month, Day, Year Hour <b>?</b> pm <b>11-13</b> 19 <b>67</b>		20d INJURY OCCURRED Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not Where <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f (City or town) (County) (State) <b>Wingate Dor. Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.		22. DATE SIGNED <b>11/20/67</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Nov 15, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d LOCATION (City or Town) (County) (State) <b>Cambridge, Maryland</b>	
24 FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a REC'D BY REGISTRAR <b>NOV 27 1967</b>	
ADDRESS		25b REGISTRAR'S SIGNATURE <b>Thomas L. Judge</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15340

1 PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c LENGTH OF STAY IN 1b <b>17 hours</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>		d STREET ADDRESS <b>R.F.D. Box 8A</b>	
3 NAME OF DECEASED (Type or print) <b>HAZEL MAE RIDEOUT</b>		4 DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1967</b>	
5 SEX <b>Female</b>	6 COLOR OR RACE <b>Negro</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>February 17, 1926</b>
9 AGE (In years lost birthday) yrs <b>41</b>		F UNDER 1 YEAR Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee Cambridge Clothing Factory</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Chester, Pennsylvania</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>Chester, Pennsylvania</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Linwood Rideout, Sr.</b>		14 MOTHER'S MAIDEN NAME <b>Rachel Dougherty</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16 SOCIAL SECURITY NO. <b>216-18-8343</b>	
17 INFORMANT <b>Nona R. Jackson, Vienna, Md., RFD</b>		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis - Embolism</b> DUE TO <b>8 hrs</b> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last) (b) <b>Myocardial Infarction</b> DUE TO <b>6 wks</b> (c) <b>Rheumatic Carditis - Fibrillation</b> DUE TO <b>2 mos</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-4-67, 1967, to 11-18, 1967</b> , that (I) (we) last saw the deceased alive on <b>11-18, 1967</b> , and that death occurred at <b>9:45 AM</b> from causes and on the date stated above			
22a SIGNATURE <b>J. J. Frampton</b>		22b. DATE SIGNED <b>11-21-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. J. Frampton</b>		22d. ADDRESS <b>Federalsburg, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>Nov. 22, 1967</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Reid's Grove Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Near Reid's Grove, Maryland</b>	
24 FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		25a REC'D BY REGISTRAR <b>NOV 27 1967</b>	
25b REGISTRAR'S SIGNATURE <b>William Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

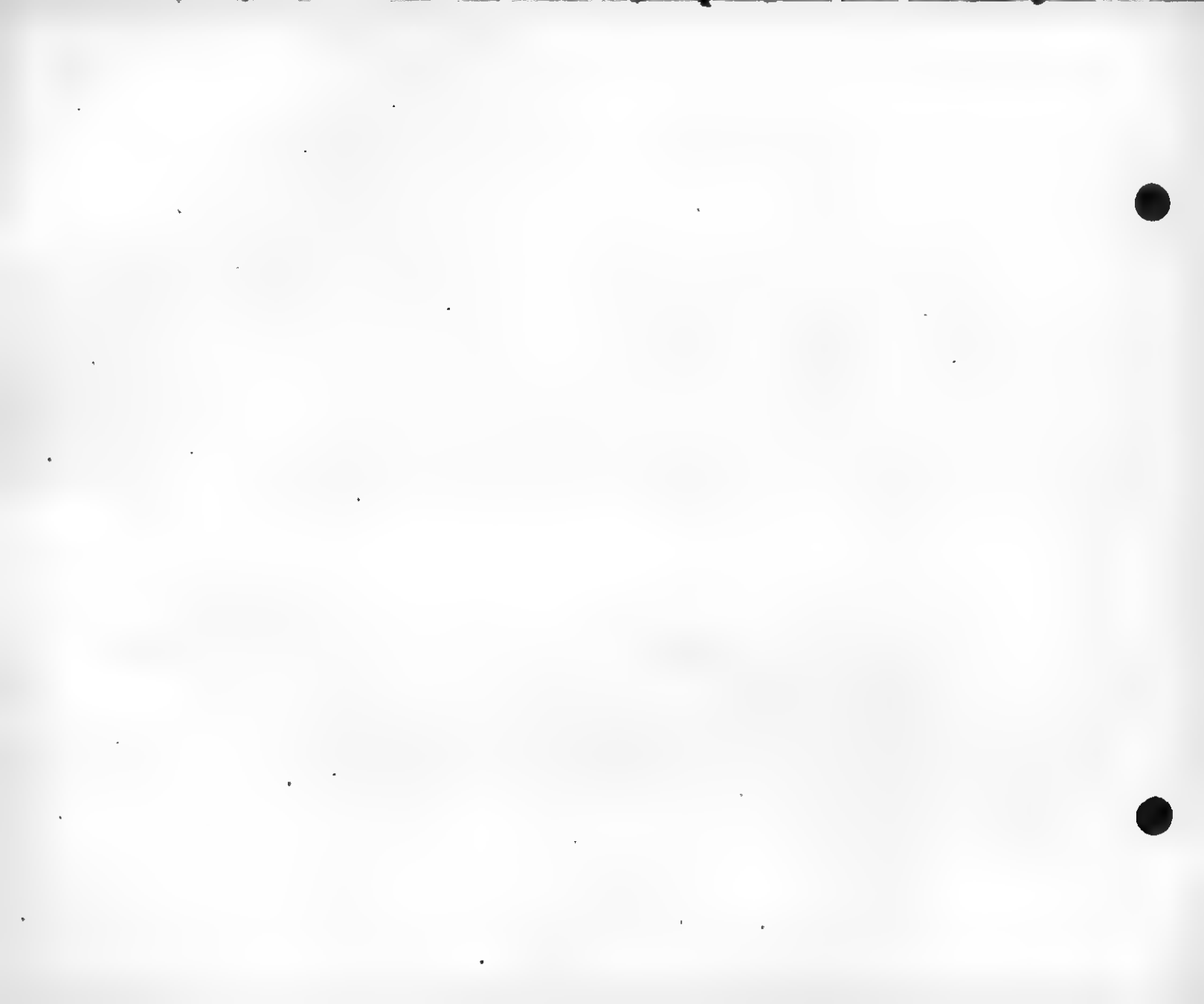
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers- Pages 1- and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M. 1/65

# DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> c. LENGTH OF STAY IN 1b <u>10</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> d. STREET ADDRESS <u>306 Boundary Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Phillips</u> Middle <u>Lee</u> Last <u>Robbins</u> <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>June 1, 1902</u> <b>9. AGE</b> (in years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			<b>4. DATE OF DEATH</b> <u>Nov. 16, 1967</u> 19 <u>  </u> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Plumber</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Cambridge</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>				
<b>13. FATHER'S NAME</b> <u>Jarvis W. Robbins</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>  </u> <b>16. SOCIAL SECURITY NO.</b> <u>217-10-8559</u> <b>17. INFORMANT</b> <u>Mrs. Lattie L. Robbins, Cambridge, Md.</u> Address: <u>306 Boundary Ave.</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Eva Lyons</u> <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEPHALIC BILIAL (ASCULAR) ACCIDENT</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town) (County) (State)</b> <u>  </u> <u>  </u> <u>  </u>			<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>7 Nov 1967</u> <b>to</b> <u>16 Nov 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>16 Nov 1967</u> <b>and that death occurred at</b> <u>11:30 P.M.</u> <b>from the causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <u>[Signature]</u> <b>22b. DATE SIGNED</b> <u>11/17/67</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>W. E. GUNNY JR.</u> <b>22d. ADDRESS</b> <u>CAMBRIDGE MARYLAND</u>				
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Nov. 17, 1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>East New Market Cemetery</u> <b>23d. LOCATION (city, town or county) (State)</b> <u>East New Market, Md.</u>			<b>24. FUNERAL DIRECTOR</b> <u>Reverend R. Thomas</u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u> <b>DATE</b> <u>NOV 24 1967</u>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE <b>Delaware</b> b COUNTY <b>/</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Cambridge</b>		c LENGTH OF STAY N 1b <b>Minutes</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>DQA Cambridge Maryland Hospital</b>		e STREET ADDRESS <b>RFD No. 2</b>	
3. NAME OF DECEASED (Type or print) First <b>PEARL</b> Middle <b>LINTHICUM</b> Last <b>SHENTON</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>10,</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 28, 1931</b>
9. AGE (In years last birthday) yrs <b>36</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>19 67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Linthicum</b>		14. MOTHER'S MAIDEN NAME <b>Mamie A. Tyler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>XXX</b>	
17. INFORMANT <b>Robt. A. Shenton, RFD2, Greenwood, Del.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple injuries, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>1234</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of auto which struck bank of road</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:30 PM</b> <b>11/10/67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>USRT. 50</b>		20f. (City or town) (County) (State) <b>Near Cambridge, Dor., Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.		22. DATE SIGNED <b>11/13/67</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 13, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity Churchyard</b>		23d. LOCATION (City or Town) (County) (State) <b>Church Creek, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REG STRAR DATE <b>NOV 15 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN ID <b>1 Month</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Golden Hill</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS <b>Rural</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eresa</b> Middle <b>Anna</b> Last <b>Strasinger</b>					4. DATE OF DEATH Month <b>Nov.</b> Day <b>8</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 15, 1893</b>		9. AGE (In years last birthday) <b>74 U.S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Seraphin Oberle</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>0</b>			16. SOCIAL SECURITY NO. <b>0</b>		17. INFORMANT <b>Harry R. Strasinger, Church Creek, d. D</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Inanition</b> DUE TO (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) <b>Coronary Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 yr</b> <b>2 yr</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10/11/67</b> to <b>11/8/67</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>11/8/67</b> , 19 <b>67</b> , and that death occurred at <b>11/8/67</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>Lawrence Marynow</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11/9/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>Lawrence Marynow</b>					22d. ADDRESS <b>Cambridge, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>Nov. 11, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery, East New Market, Md.</b>		23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR <b>Kenneth R. Thomas</b>					ADDRESS <b>Cambridge, d. D.</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Thomas Judge</b>

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH					
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201					
CERTIFICATE OF DEATH					
15344					
1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE (RURAL)</b> c. LENGTH OF STAY IN 1b <b>6 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>TALBOT</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WITTMAN</b> d. STREET ADDRESS  e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>SOPHIE</b> First Middle Last <b>THOMAS</b>			4. DATE OF DEATH Month Day Year <b>NOVEMBER 22 1967</b>		
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10/01/85</b>		9. AGE (In years last birthday) yrs <b>82</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>11/22/67</b>	
11a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>TALBOT MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>THOMAS PINKNEY</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE ALDRIDGE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>214-16-3380</b>		17. INFORMANT <b>RECORDS OF THE EASTERN SHORE STATE HOSPITAL</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Left Ventricular Heart Failure</b> 4201 DUE TO <b>M.I.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c) <b>Pneumonia</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>8 30 p.m. 11/22/67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home farm factory, street, office bldg. etc.)	
20f. (City or town) (County) (State)					
21. I certify that (s) (this hospital) attended the deceased from <b>05/09</b> , 19 <b>67</b> , to <b>11/22</b> , 19 <b>67</b> , that (s) (we) last saw the deceased alive on <b>11/22</b> , 19 <b>67</b> , and that death occurred at <b>8 30 P.M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>Stephen H Kaufman</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>11/22/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>STEPHEN H KAUFMAN M.D.</b>		22d. ADDRESS <b>EASTERN SHORE STATE HOSPITAL</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-26-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MICHAELS</b>	
23d. LOCATION (City or Town) (County) (State) <b>ST. MICHAELS, TALBOT MD.</b>					
24. FUNERAL DIRECTOR <b>Dashill Funeral Home</b>		ADDRESS <b>Dashill Funeral Home</b>		25a. RECEIVED BY REGISTRAR <b>NOV 28 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Thelma Judge</b>					



VR A15 (4)  
25M 1/67

1 PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut. an. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c LENGTH OF STAY IN 1b <b>28 YRS.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>ROSE</b> Middle Last <b>TRAVERS</b>		4 DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>19 67</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/26/03</b>
9. AGE (In years last birthday) <b>64 yrs</b>		10. UNDER 1 YEAR Months Days	11. UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>		10b KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11 BIRTHPLACE (County & State, or foreign country) <b>- Wicomico Md.</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13 FATHER'S NAME <b>FRANK M. TRAVERS</b>		14 MOTHER'S MAIDEN NAME <b>SARAH ELIZABETH TAYLOR</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>491X IMMEDIATE CAUSE (a) Broncho pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>2 days.</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>4/4</b> , 19 <b>39</b> , to <b>11/7</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>11/7</b> 19 <b>67</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Efrain C. Fernandez</b>		22b. DATE SIGNED <b>11/7/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>EFRAIN C. FERNANDEZ</b>		22d. ADDRESS <b>Eastern Shore State Hospital</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b DATE THEREOF <b>11/9/67</b>	23c NAME OF CEMETERY OR CREMATORY <b>Turners Cem.</b>	23d LOCATION (City or town) (County) (State) <b>Cambridge Md</b>
24 FUNERAL DIRECTOR <b>Edw. J. Morris, Baltimore, Md</b>		25a REC'D BY REGISTRAR <b>NOV 14 1967</b>	
25b REGISTRAR'S SIGNATURE <b>James Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A75 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>DORCHESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - CORDTOWN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CAMBRIDGE MARYLAND HOSPITAL, INC.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CLATBORNE TUBMAN</b>		4. DATE OF DEATH <b>NOVEMBER 17, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO ID</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 6, 1916</b>
9. AGE (In years last birthday) <b>51</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ERNEST TUBMAN</b>		14. MOTHER'S MAIDEN NAME <b>EVA RYDER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>217-10-8475</b>	
17. INFORMANT <b>GERALDINE TUBMAN RFD #2 CAMBRIDGE, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour : m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <b>11-14, 1967</b> to <b>11-17, 1967</b> that (1) (we) last saw the deceased alive on <b>11-17, 1967</b> , and that death occurred at <b>12:22</b> M, from causes and on the date stated above			
22a. SIGNATURE <b>James F. McCarter</b>		22b. DATE SIGNED <b>11-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>James F. McCarter, M.D.</b>		22d. ADDRESS <b>704 Locust Street</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11/20/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>UNION CHAPEL</b>	23d. LOCATION (City or Town) (County) (State) <b>CORDTOWN DOR. MD.</b>
24. FUNERAL DIRECTOR <b>Frederick C. McKee</b>		25a. REC'D BY REGISTRAR <b>NOV 27 1967</b>	
ADDRESS <b>CAMBRIDGE, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

138



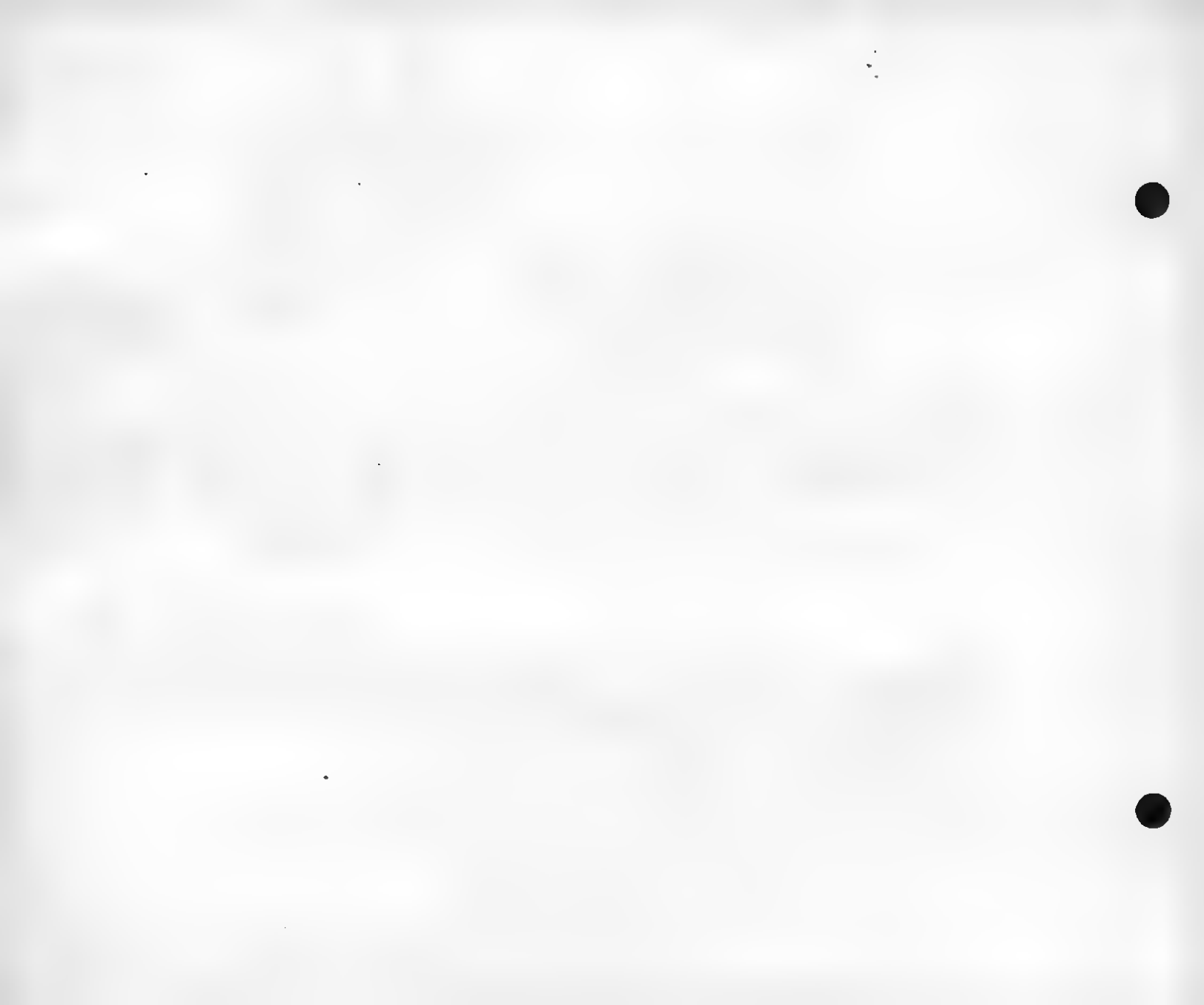
CERTIFICATE OF DEATH

15244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND X		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>		c. LENGTH OF STAY IN 1b <u>3 months 18 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		e. STREET ADDRESS —	
3. NAME OF DECEASED (Type or print) First <u>Ackley</u> Middle <u>Franklin</u> Last <u>Tyler</u>		4. DATE OF DEATH Month <u>11</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years lost birthday) <u>64</u> yrs
13. FATHER'S NAME <u>Samuel Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Susie Hooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>213-14-1963</u>	
17. INFORMANT <u>Eastern Shore State Hospital (Med. Records)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Infarction of the Myocardium</u> 4211 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>intercoronary coronary disease.</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>months</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>12</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Felipe M. Dominguez M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FELIPE M. DOMINGUEZ</u>		22d. ADDRESS <u>ESSH</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park, Cambridge, Md.</u>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <u>Rembert Thomas Jr. Cambridge Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>about 30 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>		d. STREET ADDRESS <b>110 Talbot Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>First JOSEPH Middle EDWARD Last WALTER Jr.</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 29, 1912</b>
9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Mail</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Edward Walter, Sr</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Tyler</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>214-10-0949</b>	
17. INFORMANT <b>Mrs. Ella Walter, Cambridge, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>157X</b> DUE TO <b>PANCREAS TUMOR</b> IMMEDIATE CAUSE (a) <b>CARCINOMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LIVER</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/6, 1967</b> to <b>11/7, 1967</b> , that (I) (we) last saw the deceased alive on <b>11/7, 1967</b> , and that death occurred at <b>8 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED <b>11/9/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. G. W. J. JR.</b>		22d. ADDRESS <b>CAMBRIDGE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 10, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		23d. LOCATION (City, town or county) (State) <b>Cambridge, Maryland</b>	
24. FUNERAL DIRECTOR <b>LeCompte Funeral Service, Cambridge, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It and any necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for to informants.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME  
SM 1/63

<div> <div>1</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>5348</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>15349</div> </div>												
1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b. <u>accident</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cambridge Maryland Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>603 E. College Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Larry Fred Webster</u>			4. DATE OF DEATH Month Day Year <u>Nov. 11 1967</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>boat factory</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Bennett Webster</u>						14. MOTHER'S MAIDEN NAME <u>Virginia Burton</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>216-40-4595</u>			17. INFORMANT Address <u>Anna W. Webster, 603 E. College Ave. Salisbury, Md.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intracranial injuries.</u>												
<div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div> <div>DUE TO (b) <u>Multiple skull fractures</u></div> <div>DUE TO (c)</div> </div> </div>												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
MEDICAL CERTIFICATION												
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Right front seat passenger in one car wreck.</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>11/11/67</u>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway Rt. 50</u>						20f. (City or town) (County) (State) <u>Nr. East New Market, Md.</u>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <u>John W. Ace Jr.</u>						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <u>John W. Ace Jr.</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>						22b. DATE THEREOF <u>11/13/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Deal Island, Maryland</u>		
23. FUNERAL DIRECTOR <u>Leroy G. Webster</u>						ADDRESS <u>Rt. 3, Princess Anne</u>		Md.		24a. REC'D BY REGISTRAR <u>NOV 20 1967</u>		
								24b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15350

FOR STATE  
HEALTH DEPT

1  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY in lb <b>life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Md. Hospital (DOA)</b>		d. STREET ADDRESS <b>812 Park Lane</b>	
3. NAME OF DECEASED (Type or print) <b>Barry</b> First Middle Last		4. DATE OF DEATH <b>November 1</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1967</b> 9. AGE (In years last birthday) yrs. <b>12</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Gilbert Meekins</b>		14. MOTHER'S MAIDEN NAME <b>Delphine Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>White</b> <b>Delphine Jackson</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7630</b> IMMEDIATE CAUSE (a) <b>Asphyxiation</b> (SDII) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Acute upper respiratory infection</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>11/2/67</b> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Cambridge, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/2/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge, Dor. Md.</b>
24. FUNERAL DIRECTOR <b>St. Clair Funeral Service Cambridge, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b> DATE	

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>DOR.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL CAMBRIDGE</b>		c. LENGTH OF STAY IN lb <b>10 MONTHS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>		d. STREET ADDRESS <b>600 ACADEMY ST.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARDESTY WINGATE</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 28 19 67</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/16/87</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DORCHESTER COUNTY, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>ALFORD WINGATE</b>		14. MOTHER'S MAIDEN NAME <b>SIRRY JONES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>217-54-6160T</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS OF THE TERMINAL AORTA DUE TO</b> <b>260x</b> DUE TO <b>ARTERIOSCLEROSIS (4694)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DIABETES</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>NEPHROSCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1/4</b> , 19 <b>67</b> , to <b>11/28</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>11/28</b> , 19 <b>67</b> , and that death occurred at <b>-</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Philip M. Dominguez</b> M.D.		22b. DATE SIGNED <b>11/28/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 30, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Cambridge Md.</b>
24. FUNERAL DIRECTOR <b>Kenny Shover Jr.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 4 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

170

STANDARD 100

170

170

170

170

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170